1. PURPOSE AND SCOPE

The State--Local Hospitalization (SLH) Program was established by the General Assembly in 1989 to encourage and assist counties and cities to provide medically necessary services for indigent persons. Through joint State and local funding, a program of both inpatient and outpatient hospitalization services, ambulatory surgical services, and, Health Department clinic visits, is available to those persons without resources to secure needed medical care.

2. LEGAL BASE

Title 32.1, Chapter 11, Sections 32.1 - 332 through 32.1 - 339 of the Code of Virginia authorizes the Department of Medical Assistance Services to administer the State - Local Hospitalization Program and requires the participation of each city and county in the Commonwealth.

3. FUNDING

The SLH program is funded annually by the Commonwealth through an appropriation for this purpose in an amount sufficient to meet at least seventy-five percent of the anticipated costs of the program. The remaining share of program costs are met with local government funds. The Director, Department of Medical Assistance Services is charged with the responsibility to notify each locality of the amount of its annual assessment and to collect the assessed amount from that locality in July of each year. The amount assessed each locality is based upon the ability of the locality to pay as determined from the information in the state income tax returns of its residents. However, no locality will be assessed a sum greater than twenty-five percent of the costs of providing SLH services to its indigent residents.

1. DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
The Department of Medical Assistance Services has the following responsibilities to:

a. allocate the funds available for expenditure by the SLH program.

b. communicate with the local government when their allocation is depleted.

c. issue a manual to providers and establish a toll-free SLH help line (1-800-852-6080 or in Richmond 786-6273) for providers seeking further clarification.

d. send an updated provider list to local departments every three months.

e. assess local governments for their individual share of the costs of the program.

f. establish the standards for reimbursement of services and the amount, duration and scope of medical services covered by the program which shall be the same as provided in the State Plan for Medical Assistance and uniform throughout the Commonwealth.

g. establish agreements for provision of services rendered in inpatient and outpatient hospitals, free-standing ambulatory surgical centers and local public health clinics and with providers who are enrolled providers in the Medical Assistance (Medicaid) program.

h. make the payments to providers of medical services.

i. conduct fair hearings on behalf of persons aggrieved by local departments of social services or enrolled medical service providers.

j. obtain from local departments of social services an accounting of the numbers of applications received and the disposition of each, including an estimate of the number of services required by each recipient, for the purpose of estimating the demand for SLH.

k. maintain a record of each approved application.

l. use unexpended local share funds remaining at the end of the fiscal year or biennium as an offset to the calculated local share for the following year.

m. recover erroneous payments made on behalf of recipients from the income, assets, property or estates of those recipients unless such income, assets or property are exempted by state or federal law.

n. pursue recovery of funds, expended from the SLH program, from liable third parties when such funds are determined to be available._

2. DEPARTMENT OF SOCIAL SERVICES

The State Department of Social Services has the following responsibilities:

a. establish uniform eligibility policy for the SLH program at the direction of the Department of Medical Assistance Services.

b. publish annually for the then current year, the federal non-farm poverty income level.

c. train local departments of social services staff to determine eligibility of applicants for services under the program.

3. LOCAL DEPARTMENTS OF SOCIAL SERVICES

Local departments of social services have the following responsibilities:

a. advise potential applicants, providers, or other interested members of the community of the eligibility requirements for and the availability of services provided under this program.

b. accept applications for services under this program.

c. acquaint applicants with the services provided under this program by verbal means and with a pamphlet provided for this purpose when available.

d. make determinations of eligibility/ineligibility of the applicants using uniform eligibility criteria established in this policy.

e. notify applicants of the eligibility finding using the form provided for this purpose.

f. forward notice of eligibility for participation in this program to the Department of Medical Assistance Service using the form provided for this purpose.

g. report monthly the number of applications taken and the method of disposition of these applications as required in the Department of Social Services Volume I, Local Administrative Manual.

h. assist the Department of Medical Assistance Services in that department's efforts to recover erroneous program expenditures from recipients or from liable third parties.

i. inform persons aggrieved by the application of the policies of this program to obtain a fair hearing of the grievance from the Department of Medical Assistance Services.

4. PROVIDERS

Medical service providers under this program have the following responsibilities:

a. to provide medical services to indigent persons under the terms and provisions of the contract for services executed between the provider and the Department of Medical Assistance Services.

b. to provide to local departments of social services, when requested, an estimate of the number of days of treatment required for individual recipients or potential recipients of services under this program.

1. ELIGIBLE INDIVIDUALS

a. Coverage is available to an individual who is unable to pay for needed medical services when counting income available to him/her and members of his/her household.

b. SSI, GR, AG and AFDC recipients must be excluded from the household.

c. An indigent individual must be a U.S. citizen or legal alien who is a bona fide resident of the city or county where making application at the time of or immediately prior to medical treatment and who did not establish residency for the purpose of obtaining benefits. Migrant workers are not eligible for assistance under this program. Individuals are not eligible under this program after ARREST and while in the custody of a law enforcement agency.

2. ASSIGNMENT OF RIGHTS AND COOPERATION

a. General Principles

1) A legally able applicant or recipient must assign his rights to medical care support and third party payments, and also the rights of any other individual for whom he can legally make an assignment, in order to be eligible for SLH. He/she must also cooperate with the agency by identifying any third party who is liable to pay for his/her medical care and services.

2) Parents, spouses, legally appointed guardians/committees, or attorneys-in-fact (power-of-attorney) are the only individuals who can make such an assignment if the applicant/recipient is not competent. Refusal by such persons to assign the applicant's rights will result in their own ineligibility for SLH but will not affect the eligibility of those for whom assistance is requested.

b. Eligibility Procedures

The applicant must:

1) assign to the Commonwealth of Virginia his/her rights, and the rights of any other eligible individual for whom he/she can legally make an assignment, to any medical support and other payments for medical care. This is done by reading and signing the "Assignment of Rights to Medical Assistance and Third Party Payments."

2) cooperate with the agency in obtaining medical support and payments for himself and any other individual for whom he can legally assign rights.

3) cooperate with the agency in identifying, to the extent he/she is able, potentially liable insurers and other third parties who may be liable to pay for care and medical services.

4) cooperate with the agency in providing information to assist the agency and the Department of Medical Assistance Services in pursuing payments from any third party who may be liable to pay for the individual's, and any other individual for whom he can legally assign rights, care and medical services unless such individual has good cause for refusing to cooperate.

3. RELATIONSHIP TO MEDICAID

As Medicaid and SLH cover the same services, it is not necessary to take an SLH application on an active Medicaid recipient.

However, SLH may provide assistance to individuals who are ineligible for Medicaid because of some differences in eligibility requirements. The two principle differences are income and categorical relationship requirements.

Example:

John Bailey was referred by Hampton General Hospital for assistance with a hospital bill incurred when 15-year-old John Jr. nearly drowned. John Jr. has three siblings making a five-person family unit. The only income is Mr. B's gross weekly earnings of $200 from R & S Paint Contracting Co. and that has not changed in the past three months. Resources were within allowable limits.

Medicaid/SLH Computation:

$200 x 4.33 = $866 minus $90 work expense = $776 countable income

$776 x 6 = $4,656 minus Group III income level of $3,150 leaves a spend-down of $1506

3 months average gross: $866 - $90 WE = $776 < $1178.33 SLH income level for family of 5

John Jr.'s hospital bill shows incurred expenses of $2000 by the 3rd day of his hospitalization. He is enrolled in Medicaid effective that day. His SLH application was extended pending this determination.

Therefore, Medicaid eligibility will cover all but 2 days of the hospitalization. An SLH application to cover these 2 days is appropriate.

4. DATE AND METHOD OF APPLICATION

a. Any individual wishing to file an application for assistance will be permitted to do so without delay during the normal business hours of the local department of social services in the city or county of his/her legal residence at the time of or immediately prior to medical treatment.

b. If an applicant is unable to come to the office, the agency, upon request, must arrange to have the application taken in his home or in the facility in which he is living or is a patient. No face-to-face interview is required.

c. No activity of the local department of social services in receiving or acting upon an application shall be inconsistent with the objectives of the SLH program and will be conducted in a manner which respects the personal dignity and privacy of the individual. No activity shall violate the rights of the individual applicant/recipient under the United States Constitution, the Social Security Act, Title VI of the Civil Rights Act of 1964 or any other relevant provision of state or federal law.

d. The application form for this program is the Benefit Programs Application/Redetermination Base Document, Form 032-03-1605, and the SLH Supplement, Form 032-03-160E.

e. An applicant is a person who has directly or through his authorized representative, made written application for SLH and Medicaid from the Department of Medical Assistance Services through the local social services department serving the locality in which he/she resides.

f. An applicant who is a foster care child not eligible for Medicaid must apply for assistance under this program at the department of social services having custody or responsibility for the child.

g. The application date is the date the signed application for SLH is received by the local department. If received by mail, the date of delivery to the agency must be stamped on the application.

h. If an applicant has not applied for SSI and appears to be categorically and financially eligible for that program, encourage him/her to file an SSI application. However refusal to file for SSI does not constitute a basis for the local department of social services to deny or refuse to determine eligibility.

i. An applicant for SLH must be screened for potential Medicaid eligibility. The local department of social services is not required to take a Medicaid application simultaneously with the SLH application if the applicant does not appear to meet the categorical requirements of the Medicaid program: i.e., not age 65 or older; not blind; not disabled for a period that is expected to last more than twelve consecutive months; not categorically related to AFDC; not pregnant; not a categorically eligible child. However, persons wishing to do so may file an application for Medicaid even if eligibility does not appear to exist.

5. TIME STANDARDS AND APPLICATION DISPOSITION

a. Applications for assistance must be filed before services are received or within 30 days after the date services are completed. The first day of the 30 days will be the day after the day of discharge.

b. The application processing time standards, as provided by law, require that a decision of eligibility be made and notice of that decision be provided to the applicant within thirty days of the date the application is received in the local department of social services. If additional

time is required for processing, the applicant shall be given adequate notice, mailed not later than the thirtieth day from the date of receipt of the written application, and must advise the applicant of the reason for delay and the expected date of a decision.

NOTE: An SLH application may be extended when more time is needed to secure additional verifications to determine Medicaid eligibility. However, an SLH application should not be left pending while awaiting a decision of permanent and total disability. If such cases are subsequently approved for Medicaid, DMAS will cross-check records in a post-payment review and recover SLH funds from Medicaid.

c. Each application must be disposed of by a finding of eligible or ineligible as supported by the facts in the case record, unless the application is withdrawn or terminated by the applicant or his representative.

d. When a locality's SLH funds have been fully expended:

1) do not have the applicant "withdraw" an application in process. Dispose of the application with a finding of "eligible". Hospitals will "write off" the costs of care more often when a patient has applied for SLH.

2) do continue to take SLH applications. The locality's appropriation for SLH is based on the need shown in past performance. These applications and the costs associated with them must be included in the locality's estimate of need for SLH funds.

e. Do not transfer active SLH cases. Transfer of a case implies a guarantee of continued assistance. The receiving locality may have expended funds and be unable to cover SLH costs.

When an active SLH client moves to another locality, close the case and advise the client to apply in the new locality.

6. INCOME ELIGIBILITY

To be eligible for SLH, a person shall have countable income equal to or less than 100 percent of the federal non-farm poverty level.

The total gross income of the applicant and his/her household, will be used to determine eligibility. Total gross countable income for this purpose includes all gross earned and unearned income, unless specifically disregarded.

a. Income Screening

1) Eligibility will be determined by using the poverty level scale provided annually in the Code of Federal Regulations. See Appendix I.

2) The scale is used by comparing the income of the number of household members to the scale.

b. Income Disregards

Certain types of income received by household members are disregarded.

Income sources of household members to be disregarded in determining eligibility for SLH are fully defined in the Virginia AFDC manual in Section 305. Income to be disregarded includes the sources listed here.

1) home produce of the assistance unit utilized for their own consumption.

2) the value of the food coupons under the Food Stamp Program.

3) the value of foods donated under the U.S.D.A. Commodity Distribution Program.

4) any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

5) any benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended.

6) earned income of a child who is a full-time student and earned income of a part-time student who works part-time. However income of a part-time student who works full-time is counted.

7) any grant or loan to any UNDERGRADUATE student for educational purposes made or insured under any program administered by the U. S. Commissioner of Education. Programs that are administered by the U. S. Commissioner of Education include: Pell Grant, Supplemental Education Opportunity Grant, Perkins Loan, Guaranteed Student Loan (including the Virginia Education Loan), PLUS Loan, Congressional Teacher Scholarship Program, College Scholarship Assistance Program, and the Virginia Transfer Grant Program.

8) any funds derived from the College Work Study Program.

9) a scholarship, loan, or grant obtained and used under conditions which PRECLUDE its use for current living costs.

10) training allowances (transportation, books, required training expenses, and motivational allowances) provided by the Department of Rehabilitative Services (DRS) for persons participating in vocational rehabilitation programs. The disregard is not applicable to the allowance provided by DRS to the family of the participating individual.

11) any portion of an SSI, Auxiliary Grant, AFDC, or General Relief payment.

12) payments to VISTA Volunteers under Title I, when the monetary value of such payments is less than minimum wage as determined by the Director of the Action Office, and payments for services of reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and other programs pursuant to Titles II and III, of Public Law 93-113, the Domestic Volunteer Service Act of 1973. The worker must contact the Action Office at the following address or telephone number when VISTA payments are reported: Action Office, 400 N. 8th Street, Richmond, Virginia, 23219, (804) 771-2197.

13) refunds made to the family by the Division of Child Support Enforcement which represents the difference between the deficiency and the maximum assistance payment allowed by the statewide standard (90%) of need. This payment is to prevent the reduction of total income available to the family in those situations where the income would have been reduced because of the redirection of support. This type refund is referred to as "Hold Harmless Payments."

14) The Veterans Administration educational amount for the caretaker 18 or older when it is used specifically for educational purposes. Any additional money included in the benefit amount for dependents is to be counted as income to the assistance unit.

15) foster care/adoption subsidy payments received by anyone in the assistance unit.

16) any unearned income received from the Jobs Corps by a child as an incentive payment. However, any payment received by any other Job Corps participant or any payment made on behalf of the participant's eligible child(ren) is to be counted as income to the assistance unit.

17) income tax refunds including earned income tax credit advance payments and refunds.

18) any payment made under the Fuel Assistance Program.

19) the value of supplemental food assistance received under the Child Nutrition Act of 1966. This includes all school meals programs; the Women, Infants, and Children (WIC) Program; and the child care food program.

20) HUD Section 8 and Section 23 payments.

21) any unearned income received by an eligible child under Title II, Parts A and B, and Title IV, Part A and B, Job Corps (incentive payments) of the Job Training Partnership Act (JTPA).

22) any funds distributed to, or held in trust for, members of any Indian tribe under Public Law 92-354, 93-134, 94-540, 98-64, 98-123, or 98-124. Additionally, interest and investment income accrued on such funds while held in trust, and purchases made with such interest and investment income.

23) tax exempt portions of payments made under the Alaska Native Claims Settlement Act (Public Law 92-203).

24) income derived from certain submarginal land of the United States which is held in trust for certain Indian tribes (Public Law 94-114).

25) the first $50 of total child/spousal support payments received each month by a member included in the eligibility determination.

26) payments sent to the recipient by the State which are identified as disregarded support.

27) federal major disaster and emergency assistance provided under the Disaster Relief and Emergency Assistance Amendments of 1988 and disaster assistance provided by state and local governments and disaster assistance organizations (Public Law 100-707).

28) payments received by individuals of Japanese ancestry under the Civil Liberties Act of 1988, and by Aleuts under the Aleutian and Pribilof Islands Restitution Act (Public Law 100-383).

29) payments by ESP for support services such as transportation, uniforms, child care, etc.

30) any payment received from the Agent Orange product liability litigation. To verify whether a payment is an Agent Orange payment, use documents in the individual's possession. If the individual cannot provide verification or the situation is unclear, write to the Agent Orange Veteran Payment Program, P. O. Box 110, Hartford, CT 06104, Attention: Agent Orange Verification. Include in the request the veteran's name and social security number. If a survivor of a qualifying veteran was paid, also provide the survivor's name and social security number.

7. INCOME COMPUTATION

Income eligibility for all applicants is based on a prospective determination which anticipates the total countable earned & unearned income of the household.

a. Income To Be Counted In Determining Eligibility

Income eligibility is to be determined using the methods listed below. The household's circumstances must be evaluated to determine which method(s) will provide the amount of income anticipated (best estimate) to be received in the month of application or the processing month, whichever is later.

For purposes of determining the amount of income to be counted in determining eligibility, anticipated income means any income the applicant and local agency are reasonably certain will be received during the application/processing month. If the amount of income or when it will be received is uncertain, that portion of the household's income that is uncertain shall not be counted by the local agency.

"Reasonably certain" means that the following information is known:

- who the income will come from,
- in what month it will be received, and
- how much it will be (i.e., rate, frequency and payment cycle).

b. Methods Used To Anticipate the Income

The income generally to be counted is the income verified for the calendar month prior to the month of application. However, if the income for the prior month is not the amount anticipated to be received in the application/processing month, the Eligibility Worker must work with the household to determine how the correct amount can be anticipated.

The following methods are to be used to anticipate the household's income when the prior month's income does not reflect the income anticipated for the application/processing month.

1) The Eligibility Worker shall take into account the income already received by the household during the application process and any anticipated income the household unit and local agency are reasonably certain will be received during the month of application/processing. Eligibility workers should not automatically project amounts of past income to the household to assume that current income will continue without exploring the situation with the household. Past income shall not be used as an indicator of future income when changes in income can be anticipated.

2) If income fluctuates so much that the prior calendar month cannot by itself provide an accurate indication of anticipated income, a longer period of past time may be used if it will provide a more accurate indication of fluctuations in future income. If income is ongoing, anticipate by averaging income from the past pay periods.

   When using this method, the following procedures must be applied:

   a) verify at least four consecutive, recent pay amounts;

   b) evaluate other factors with the applicant to determine if the amounts verified are representative of the amount expected to be received in the month of application/processing.

   c) average the representative amounts to determine the amount of income to use.

3) If the household's income fluctuates seasonally, it may be appropriate to use the most recent season, rather than the calendar month prior to the month of application, as an indicator of income. However, the Eligibility Worker should use caution in using income from a past season as an indicator of income now, since in many cases of seasonally fluctuating income, the income also fluctuates from one season in one year to the same season in the next year.

4) For seasonal farm worker households, the judgment of the Eligibility Worker that income is reasonably certain to be received is to be based on formal or informal commitments for work for individual assistance units, rather than on the general availability of work in an area. Also, income should not be based on an assumption of optimum weather or field conditions.

5) Income deemed available to an alien from the alien's sponsor is calculated based on current policy in the Virginia Aid to Families with Dependent Children Program at section 305.4D.

6) Households receiving monthly or semi-monthly income, such as state or federal payments or semi-monthly pay checks, must have the income assigned to the normal month of receipt, even if mailing cycles, weekends or holidays cause the income to be received in a different month.

For example, the applicant is employed and is paid semi-monthly on the first and sixteenth. Because June 1 falls on a Saturday, the client receives her June 1 paycheck on May 31. The Eligibility Worker will count the paycheck received May 31 as income for June.

7) If the household will receive less/more than a full month's pay, either the exact amount of income, if it can be anticipated, or an average per pay period times the actual number of periods, can be used.

c. Determining the Gross Income

1) Weekly & Bi-weekly Income (earned & unearned)

a) Whenever income is anticipated for each pay period in a given month and the income received on a weekly or bi-weekly basis varies, the Eligibility Worker shall convert the income to a monthly amount by multiplying average weekly amounts by 4.3 and average bi-weekly amounts by 2.15; or,

Example 1:

The client's weekly pay for the prior month was:

$220.40
$175.80
$210.00
$195.70

To obtain a monthly amount, the Eligibility Worker multiplies the weekly average by 4.3.

$801.90 (total of the pay stubs) divided by 4 (number of paystubs) equals $200.48.

$200.48 x 4.3 = $862.06 monthly income.

Example 2:

The client's bi-weekly pay for the prior month was:

$185.40
$209.50
$394.90

To obtain a monthly amount, the Eligibility Worker multiplies the bi-weekly average by 2.15.

$394.90 (total of the pay stubs) divided by 2 (number of pay stubs) equals $197.45.

$197.45 x 2.15 = $424.52 monthly income.

b) Whenever income is anticipated for each pay period in a given month and the income received on a weekly or bi-weekly basis DOES NOT vary and frequency of receipt for the month is already known or can be anticipated, the EW shall convert the income to a monthly amount by multiplying the amount times the pay periods.

Example:

The client's salary is $100 weekly. The pay does not vary. The applicant is paid every Friday.

The Eligibility Worker can project the exact monthly income because the pay does not vary and the pay dates are known.

$100 x 4 = $400 for months when 4 pay dates are due.

$100 x 5 = $500 for months when 5 pay dates are due.

When exact monthly figures are used, it is the Eligibility Worker's responsibility to adjust the figure for the months a fifth weekly or a third bi-weekly pay check is received.

2) Self Employment Income

Self-employment is defined as a business; farming, or commercial enterprise in which the individual receives income earned by his own efforts, including his active management of property. NOTE: Income from rent or room and board is not earned income unless the activity engaged in is a business enterprise.

Profit from self-employment income is prorated on an annual basis or over the number of months in which the income is earned, whichever is appropriate.

Profit from self-employment means the total income received, less the business expenses directly related to producing the goods or services and without which the goods or services could not be produced.

a) Business expenses do not include:

(1) payments on the principal of the purchase price of, and loans for, capital assets, such as real property, equipment, machinery and other goods of a durable nature;

(2) the principal and interest on loans for capital improvement of real property;

(3) net losses from previous periods;

(4) federal, state, and local taxes;

(5) money set aside for retirement purposes;

(6) personal expenses, entertainment expenses, and personal transportation; and

(7) depreciation of equipment, machinery, or other capital investments necessary to the self-employment enterprise.

b) Specific Types of Self Employment Income: Use the following methods to determine the profit from these types of self-employment.

(1) board--profit is monthly gross income from boarders, less food allowance for one person living in a group (at 100%) per boarder. (Table 1, Appendix 2, Section 305 in AFDC manual).

(2) room rent--Profit is 65% of monthly gross income received if heat is furnished, 75% of gross income if heat is not furnished.

(3) room and board--Make the deduction for boarder(s) as in 1); then apply formula in 2) to balance.

(4) children in family day care--when this service is provided in client's home to children other than those living in the same home, deduct from the average monthly gross income the cost of meals and snacks that are provided during the period the income was earned. Allow 40› per meal per day. Determine the number of days in the period in which the income was earned in which meals are provided for each child. Add to obtain the total number of meals provided during the period and multiply by 40› to obtain the monthly cost of meals provided for all children. The total monthly cost of snacks is computed by the same method as meals, with 20› allowed for each snack.

Add the total monthly costs of meals and snacks to obtain the total cost of food provided.

Deduct the monthly cost of food from the total income anticipated for day care.

Sixty-five percent of the balance is considered as profit from self-employment.

d. Determining the Net Countable Income

1) Earned Income

These steps should be followed for each household member whose income is counted.

a) deduct the standard $90 work allowance from the gross income for each member of the household whose income is not exempted.

b) deduct actual expenses, up to the allowable maximum for care of each child/incapacitated adult in care from an applicant's earnings based on his/her employment status as follows:

(1) working, or expected to work, 120 hours or more per month, deduct actual expenses up to a maximum of $175 per month, except that for care of a child under two years of age, deduct actual expenses up to a maximum of $200 per month.

(2) working, or expected to work, less than 120 hours per month, deduct up to $120 per month.

(3) if an individual is not employed throughout a month but:

(a) has worked, or is expected to work, 120 hours or more in that month, deduct an amount not to exceed $175.

(b) has worked, or is expected to work, less than 120 hours in that month, deduct an amount not to exceed the part-time disregard.

c) the result is the net countable earned income for each individual.

2) Add the net earned and unearned income of household members together. The result is the net countable income for the SLH household.

3) Compare net countable income for the SLH household to the poverty scale for the appropriate household size. If net countable income for the SLH household is equal to or less than the appropriate figure from the poverty scale, financial eligibility exists.

e. Verification of Income (Earned & Unearned)

All earned and unearned income of the household must be verified and used in the determination of eligibility. The worker must document the case record regarding the rate and frequency of all types of income as well as the source.

When verbal verification is obtained, the case record documentation shall include the name and telephone number of the individual who provided the information, the date of contact, and the information obtained.

When attempts to verify countable income prove to be unsuccessful because the person or organization who is to provide the verification fails to cooperate with the household and the local agency (and there are no alternate sources of verification available) the Eligibility Worker shall determine an amount to be used based on the best available information. The following verification will be considered the best available information:

1) a third party statement;

2) a collateral contact; or

3) as a last resort, the applicant's/recipient's written statement of the amount of income anticipated to be received.

Once the income has been verified, eligibility can be determined based on the anticipated income. The case record must be documented to reflect the method used to arrive at the anticipated income.

8. RESOURCE EVALUATION

In order to be eligible for SLH, applicants shall have net countable resources equal to or less than the current resource standards of the federal Supplemental Security Income program.

a. The maximum countable value of resources not disregarded shall not exceed $2,000 for one person or $3,000 for two or more persons. These values are those established for the Supplemental Security Income (SSI) program. Eligibility does not exist when these limits are exceeded.

b. All real and personal property for which the applicant/recipient has legal ownership will be considered in determining eligibility.

c. Refunds of child support from the Division of Child Support Enforcement identified as closed case refunds must be considered in relation to the allowable reserve.

d. Allowable Reserves - The following are allowable reserves, ownership of which does not affect eligibility.

1) The home in which the applicant lives and the home's contents: The home is the house, lot, AND ALL CONTIGUOUS PROPERTY. THIS EXEMPTION WILL ALSO APPLY TO ANY BUILDINGS, IN ADDITION TO THE HOUSE, WHICH ARE SITUATED ON THE PROPERTY. IF INCOME IS RECEIVED FROM THE USE OF THE PROPERTY OR BUILDINGS ON IT, HOWEVER, THE INCOME WILL BE CONSIDERED AVAILABLE TO THE APPLICANT/RECIPIENT.

Contiguous property is DEFINED AS the land, and improvements, which is not separated from the HOUSE LOT by land owned by others. Streams and public rights of way which run through the property and separate it from the HOME will not affect the property's contiguity.

2) One motor vehicle with an equity value of $1,500 or less. (Equity in excess of $1,500 must be evaluated as an available resource.)

3) Property (real and personal) owned solely by any individual in the household who is receiving SSI.

4) Income producing farming and business equipment.

5) Cash and other assets, (including liquid assets and real and personal property not listed above) not to exceed the allowable reserve. Liquid assets are those properties in the form of cash or other financial instruments which are convertible to cash.

6) Burial plots, one per member of the household.

7) Funds set aside for burial, such as revocable burial contracts, burial trusts, and any separately identifiable assets which are clearly designated as set aside for the expenses connected with the burial, cremation, or other funeral arrangements with an equity value of $1,500 or less per assistance unit member. (Equity in excess of the $1500 must be evaluated as an available resource.)

e. Determining the Value of Property - The value of assets as a resource to the individual or family is the applicant's equity in the property, real or personal. Equity is defined as the fair market value minus encumbrances (legal debts) against the property.

Fair market value for specific items is determined as follows:

1) Real Property - The fair market value of real property other than the home shall be obtained from the assessor's office or the Commissioner of Revenue in the locality where the property is located.

   If property is jointly owned, the expected cost of partitioning and attorney fees will be considered in establishing equity value.

   If the applicant/recipient disagrees with the fair market value established by the agency for resources, he/she may dispute the finding by obtaining from qualified, disinterested parties two written statements/estimates indicating the value of the resource in question. The worker will accept the average of the two estimates, the current agency established value, or reassessed value, whichever is less as the fair market value for the purpose of the eligibility determination.

2) Motor Vehicles - The fair market value of a motor vehicle must be determined by using (1) the National Automobile Dealers Association Appraisal Guides or (2) a licensed dealer's statement, whichever is appropriate, using only the following criteria.

   The average trade-in value listed in the current NADA Used Car Guide or the loan value listed in the NADA Older Car Guide is considered the fair market value from which encumbrances must be deducted in order to establish equity value. There shall be no adjustments made to the average trade-in value or the loan value amount specified in the NADA Guides for optional features, special equipment for the handicapped, mileage, condition, operability, etc.

   Equity value of motor vehicles not listed in the current NADA Guides will be established based on the statement of a licensed dealer, minus encumbrances, if any. In instances in which a motor vehicle is not listed in the current NADA Guides, the applicant is responsible for obtaining a licensed dealer's statement unless assistance is requested in establishing the value. If assistance is requested, the EW must contact a licensed dealer to ascertain the fair market value.

If only one motor vehicle is owned by the household and that motor vehicle has an equity value in excess of $1,500, the excess shall be used in computing the countable resources.

If two or more motor vehicles are owned by the household, the applicant/recipient must be told the equity value and allowed to decide which motor vehicle will be exempt up to $1,500. The combined equity value in all other motor vehicles plus any excess equity in the exempt vehicle shall be used in computing countable resources.

If two or more motor vehicles are owned by the household and are covered by ONE LOAN, the equity of each will be determined as follows:

a) Determine the NADA value of each vehicle

b) Add the values to get a total value

c) Divide the value of each vehicle by the total value to determine the percent of value to assign to each vehicle.

d) Apply the percent of value in c) for each vehicle, to the total loan amount to determine the loan amount to apply to each vehicle.

e) Subtract the loan amount assigned to each vehicle (from d) from the NADA value of each vehicle to determine the equity in each vehicle.

3) Insurance--The cash value of life insurance policies which can be cashed in by any member of the household must be verified and shall be used in computing countable resources. Contact must be made with the insurance company to verify the cash value and to inquire about any other insurance policies the applicant might have with the company. The chart shown on the policy will be used to determine eligibility pending the reply from the insurance company.

4) Loans - All loans, except those used for current living expenses, will be considered available resources. Current living expenses shall include items, such as the cost of food, clothing, shelter and other day-to-day living expenses for the current month, in which the loan was received. For example, a loan obtained to buy a new car is considered a resource. A loan received to pay current rent is considered income.

f. Resources in Excess of Allowable Reserves--When an otherwise eligible applicant has resources that exceed the allowable reserves he/she is ineligible for SLH. There is no provision in SLH for disposition of excess resources.

g. Disregarded Resources:

1) the value of the food coupons issued under the Food Stamp Program.

2) the value of foods donated under the USDA Commodity Distribution Program.

3) any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

4) any benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended.

5) any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the U. S. Commissioner of Education. Programs that are administered by the U. S. Commissioner of Education include: Pell Grants, Supplemental Educational Opportunity Grants, Perkins Loans, Guaranteed Student Loan (including Virginia Education Loan), PLUS Loan, Congressional Teacher Scholarship Program, College Scholarship Assistance Program, and the Virginia Transfer Grant Program.

6) the value of supplemental food assistance received under the Child Nutrition Act of 1966. This includes all school meal programs, the Women, Infants and Children (WIC) program and the Child Care Food Program.

7) payments to VISTA volunteers under Title I, when the monetary value of such payments is less than minimum wage as determined by the director the ACTION Office, and payments for services of reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executive (SCORE) and Active Corps of Executive (ACE) and other programs pursuant to Titles II and III, of the Public Law 93-113, the Domestic Volunteer Service Act of 1973. The worker must contact the Action Office at the following address or telephone number when VISTA payments are reported: Action Office, 400 North 8th Street, Richmond, Virginia 23219, 804-771-2197.

8) any funds distributed to, or held in trust for, members of an Indian tribe under Public Law 92-254, 93-134, 94-540, 98-64, 98-123, or 98-124. Additionally, interest and investment income accrued on such funds while held in trust, and purchases made with such interest and investment income, are disregarded.

9) tax exempt portions of payments made under the Alaska Native Claims Settlement Act (Public Law 92-203).

10) income derived from certain submarginal land of the United States which is held in trust for certain Indian tribes (Public Law 94-114).

11) disregarded support payments which were sent to the recipient by the State or determined to be a disregard by the worker.

12) tools and equipment belonging to a temporarily disabled member of the assistance unit during the period of disability, when such tools and equipment have been and will continue to be used for employment.

13) federal major disaster and emergency assistance provided under the Disaster and Relief Emergency Assistance Amendments of 1988 and disaster assistance provided by state and local governments, and disaster assistance organizations (Public Law 100-707).

14) payments received by individuals of Japanese ancestry under the Civil Liberties Act of 1988, and by Aleuts under the Aleutian and Pribilof Islands Restitution Act (Public Law 100-383).

15) earned Income Tax Credit refunds and advance payments, in the month of receipt. However, any portion of the refund or advance payment retained after the month of receipt will be considered with all other resources in relationship to the allowable reserve.

16) any payment received from the Agent Orange Settlement Fund or any other fund established in response to the Agent Orange product liability litigation. To verify whether a payment is an Agent Orange payment, use documents in the individual's possession. If the individual cannot provide verification or the situation is unclear, write to the Agent Orange Veteran payment Program, P. O. Box 110, Hartford, CT 06104, Attention: Agent Orange Verification. Include in the request the veteran's name and social security number. If a survivor of the qualifying veteran was paid, also provide the survivor's name and social security number.

h. Co-Mingling of Resources

These disregarded resources will continue to be disregarded as long as they are kept separate from the allowable reserves. In the event any funds derived from items above are combined with other resources (except Food Coupons and Commodities) they must be considered in determining eligibility under this program.

1. DATE OF ENTITLEMENT/ELIGIBILITY PERIOD

a. For persons hospitalized on or after July 1, 1989, the date of entitlement to payment for medical services under this program begins on that day so long as an application for SLH assistance is made within thirty days of discharge from the hospital for that continuous period of hospitalization.

For persons receiving out-patient treatment, care in ambulatory surgical facilities, or Health Department clinics, on or after July 1, 1989, the day of entitlement is the date the medical service was rendered, so long as an application for SLH assistance is made within thirty days of the service date.

b. An eligibility decision favorable to the applicant shall remain in effect for a period of 179 days following the date of the first service covered by the current application. If the application is made for a service not yet performed (a pre-authorization request) the 180 day period begins with the date of application.

1. PURPOSE AND SCOPE

a. Legal Base

The Code of Virginia requires that the Department of Medical Assistance Services provide individuals affected by the administration of the State Local Hospitalization Program an opportunity for a fair hearing. The act establishes the right of any individual to appeal to, and receive a fair hearing before, the administering agency when he is dissatisfied with:

1) an action to deny his claim for assistance,

2) failure to act on his claim for assistance with reasonable promptness,

3) an application of agency policy affecting his claim for assistance, or

4) any other action affecting his receipt of SLH.

b. Participants

The Department of Medical Assistance Services provides the Hearing Officer for, and arranges, the fair hearing. The agency taking the action being appealed (the local social services department, local health department, Department of Medical Assistance Services or medical provider), and the appellant (the individual appealing some aspect of his entitlement to SLH) or his representative must participate in the hearing.

c. Notification and Rights

1) Notification requirements

At the time of application or redetermination, and at the time of any action or proposed action affecting his eligibility for SLH or medical services, each applicant for and recipient of SLH shall be informed in writing of his right to a hearing. He shall also be notified of the method by which he may obtain a hearing, and of his right to represent himself at the hearing or to be represented by an authorized representative such as an attorney, relative, friend, or other spokesman.

2) Notification forms

When the local social services department takes action on an individual's application for SLH, the following forms must be used form, "Notification of Action on SLH," is used to notify the applicant of the action taken, or of failure to take action within 30 days.

2. LOCAL AGENCY CONFERENCE

a. Time Limit

A dissatisfied applicant or recipient must be given the opportunity to request a local agency conference. The conference must be scheduled within 10 working days of receiving a request for a conference.

b. Conference Procedures

At the conference, the recipient must be:

1) given an explanation of the action;

2) allowed to present any information to support his disagreement with the action;

3) allowed to represent himself or be represented by an authorized representative such as a legal counsel, friend, or relative.

c. Failure to Request a Conference

The applicant's or recipient's failure to request a conference does not affect his right to appeal to the State agency within 30 days

d. The Conference/Right to Appeal

The local agency conference must not be used to interfere with the appellant's right to a fair hearing before the State Department of Medical Assistance Services.

e. Decision Notification

1) The local agency conference may or may not result in a change in the agency decision to take the action in question.

2) If the agency decision is not to take the action indicated on the "Notification of Action on SLH" the applicant or recipient must be so advised in writing and a notation of the changed action must be entered on the agency copy of the notice.

3) If the agency decision is to stand by its action, the recipient must be so advised but written notice of this decision is not required.

f. Right to Appeal Conference Decision

If the recipient is not satisfied with the agency action following the conference and wants to request a fair hearing before the State agency, he must be given that opportunity and be given any needed assistance to file an appeal.

g. Reversal of Decision Prior to Appeal Hearing

An agency can reverse its decision to deny SLH at any time between making the original decision and when a decision is rendered by the Appeals Board. Such a change may occur due to changes such as receipt of previously unavailable or unknown information, or reevaluation of the case circumstances. If the agency changes its decision, the applicant/recipient and the Hearing Officer must be notified in writing of the change.

4. APPEAL REQUEST PROCEDURES

a. Appeal Definition

1) An appeal is a request for a fair hearing. The request must be a clear expression of an applicant or recipient, his legal representative (such as a guardian, committee, or person having power of attorney), or his authorized representative acting at his request, of a desire to present his case to a higher authority.

2) The appeal request must be written. It may be a letter or a completed Form MAP 200, "Appeal to the Virginia Medical Assistance Appeals Board."

3) The appeal must be signed by the appellant or his/her legally appointed guardian, committee, or power-of-attorney.

b. Where to File an Appeal

Appeals must be sent to the Department of Medical Assistance Services, Appeals Unit, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

c. Assuring the Freedom to Appeal

The freedom of appeal must not be limited or interfered with in any way. When requested to do so, the agency shall assist the appellant in preparing and submitting his request for a fair hearing.

d. Appeal Time Standards

1) A request for a hearing must be made within 30 days of receipt of notification that an application for SLHis denied, that it has not been acted upon with reasonable promptness, that the agency proposes to take action or to apply agency policy affecting the appellant's receipt of SLH, or that his request for a medical service has been denied.

2) Notification is presumed received by the applicant/recipient within three days of the date the notice was mailed, unless the applicant/recipient substantiates that the notice was not received in the three-day period through no fault of his/her own.

3) The Department of Medical Assistance Services (DMAS) will, at its discretion, grant an extension of the time limit for requesting a fair hearing if failure to comply with the time limit is due to a good cause such as illness of the appellant or his representative, failure to have been notified of the right to appeal, or delay due to the postal service or to an incorrect address.

e. Appeal Validation

1) Following receipt of a written request for a hearing, the DMAS Chief Hearing Officer will determine whether the request is valid and will notify the appellant of the appeal's status. A valid appeal is one that appeals an action over which the Appeals Board has hearing authority, and that is received within the time limit or extended time limit.

2) When an appeal is found valid, the Department of Medical Assistance Services will notify the appellant and request an appeal summary from the appropriate local agency.

4. LOCAL AGENCY APPEAL SUMMARY

a. Once an appeal of an agency action has been validated, the agency must complete an appeal summary, "Statement of Local Department of Social Services, Health or Medical Provider." The agency must send one copy of this form to each of the following:

1) Department of Medical Assistance Services, Recipient Appeals Unit, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

2) the agency's Regional Office.

3) the appellant or his authorized representative, if requested.

b. The agency must keep a copy of the appeal summary for its records.

5. THE HEARING PROCEDURE

a. The Hearing Officer

A qualified, impartial representative of the Department of Medical Assistance Services will conduct the hearing. This individual, the Hearing Officer, must not have been

directly involved in the initial decision being appealed. The Hearing Officer will schedule the hearing at a time, date, and place convenient to the appellant and the involved agency.

b. Informal Procedure

1) To best serve the appellant's interest, the hearing will be conducted in an informal manner. Formal rules may not be used to suppress the appellant's right to a fair hearing or to present evidence (Goldberg vs. Kelly 397 US 245 [1970]).

2) The appellant will present his own case or have it presented by an authorized representative. He will be allowed to bring witnesses, establish all pertinent facts and circumstances, advance any testimony or evidence, and confront adverse witnesses.

3) The appellant or his representative must be given the opportunity to examine all documents and records to be used at the hearing, at a time before the hearing or during the hearing.

c. Hearing Officer Evaluation, Recommendation, Decision

1) Evaluation

Following the hearing, the Hearing Officer prepares a report of the hearing which includes the summary prepared by the agency or medical provider involved, evidence provided by the appellant or his representative, and additional information provided by the agency or gathered by the Hearing Officer. The Hearing Officer evaluates all evidence and either decides on the correctness (according to established policy) of the action being appealed, or recommends a decision to the Appeals Board.

2) Hearing Officer Decision

a) The Hearing Officer will usually make decisions on appeals when the issue is one of State or Federal policy if the facts of the case are not in dispute.

b) The appellant and the agency will be notified in writing of these decisions and of their right to request a review of that decision by the Appeals Board, if the request for this review is made within 15 days of the Hearing Officer's decision.

3) Recommendation to Appeals Board

a) In all other appeal cases, the Hearing Officer recommends a decision to the Appeals Board. The Board decides whether the action is correct according to established regulations, policy, or procedure, either adopting or rejecting the Hearing Officer's recommendation. The Board may refer the case back to the Hearing Officer for more information.

b) If a member of the Board has been directly involved in the action being appealed in a specific case, he shall not participate in the Board's decision on that case.

c) The appellant and the agency will be notified in writing of the Appeal Board's decision.

d. Local Agency Action

1) Agency Response

If the agency's action or proposed action is sustained, that action must be taken. Proposed cancellation actions must be taken effective the date the agency receives the Board's decision. If the agency's action is reversed, the action must be rescinded.

2) Cancellation of Assistance

a) Following a Medicaid Appeals Board decision that a proposed agency action to cancel coverage is sustained, the case must be closed without an additional notice to the recipient from the local agency. The Appeals Board letter to the appellant is the appropriate official notice of cancellation.

b) The local agency must take action to close the case.

c) In the event the Appeals Board decision reverses the local agency's proposed action to cancel, coverage must be continued or reinstated.

6 FINALITY AND RECONSIDERATION

a. Finality

The decision of the Medicaid Appeals Board is the final administrative decision on a SLH applicant/recipient issue.

b. Reconsideration

1) If the appellant does not agree with a decision reached by the Appeals Board, a reconsideration can be requested in writing to: Director, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

2) Such a request must include an exact statement of the reasons for disagreement with the decision of the Appeals Board. A request must be made within 30 days of issuance of the Appeals Board decision.

3) The Board will only reconsider a decision if new evidence of law or of fact, not available to the appellant or agency at the time of the hearing and which is relevant to the issue, is presented. No further administrative reviews of Appeals Board decisions are possible.

4) If the local agency questions, or does not understand, the Board's decision, the local agency may ask for a clarification of the Board's decision. The request must be sent to the Eligibility and Appeals Manager, DMAS, 600 E. Broad Street, Suite 1300, Richmond, VA 23219. If the agency questions the decision, it should state clearly why it questions it and cite policy, regulations, and/or law that supports its position. The Board will not formally reconsider a decision based on an agency's question, but it will explain or clarify the decision for the agency.

1. SERVICES PROVIDED

For persons hospitalized on or after July 1, 1989, the date of entitlement to payment for medical services under this program begins on that day so long as an application for SLH assistance is made within thirty days of discharge from the hospital for that continuous period of hospitalization.

For persons receiving out-patient treatment, care in ambulatory surgical facilities, or Health Department clinics, on or after July 1, 1989, the day of entitlement is the date the medical service was rendered, so long as an application for SLH assistance is made within thirty days of the service date. An applicant may establish entitlement to subsequent out-patient, ambulatory surgical care, or clinic visits subsequent to the first SLH covered visit on or after July 1, 1989, by requesting reevaluation of his/her original approval date or by reapplication for SLH within thirty calendar days of the subsequent visits.

1. ELIGIBLE INDIVIDUALS

a. Coverage is available to a migrant farm worker on the Eastern Shore who is unable to pay for needed medical services either by himself or by those with whom he lives among whom legal responsibility exists. A migrant farm worker is a seasonal farm worker who has to travel such a distance to do farm work that he/she is unable to return to his/her permanent residence within the same day. This definition is to be used whenever policy refers to migrant farm worker.

Spouses are legally responsible for each other and parents are responsible for children and stepchildren under 18.

2. The local agency will verify the following:

a. the applicant is currently employed as a migrant laborer in Accomac or Northampton County;

b. the applicant resides in a migrant labor camp or similar facility (a copy of a lease, a rent receipt or a letter from the individual providing the housing can be used to document that the applicant lives in migrant housing);

c. when the applicant is an alien, legal status will be verified by applicant's declaration. The local agency may not require written verification of legal alien status.

d. Persons who receive Medicaid are not eligible.

3. RELATIONSHIP TO MEDICAID

As Medicaid and SLH cover the same services, it is not necessary to take an SLH application on an active Medicaid recipient. However, SLH may provide assistance to individuals who are ineligible for Medicaid because of some differences in eligibility requirements. The two principle differences are income and categorical relationship requirements.

The 2007 Poverty Income Guidelines for Virginia are:

Family Size	Annual Income	Monthly Income
1	$10,210	$ 851
2	13,690	1,141
3	17,170	1,431
4	20,650	1,721
5	24,130	2,011
6	27,610	2,301
7	31,090	2,591
8	34,570	2,881

For family units greater than eight members, add $3,480 to the annual income and $290 to the monthly income for each additional member.

The Maximum Resource Level is:

Family Size	Resource Limit
1	2,000
2 or more	3,000